431 – COPAYMENT

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I. PURPOSE

This Policy applies to AHCCCS Complete Care (ACC), ALTCS/EPD, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors. The purpose of this Policy is to outline the copayment requirements described in A.A.C. R9-22-711, including mandatory and non-mandatory copayment amounts for certain populations, and provide clarification on services and populations which are exempt from copayments. The copayments referenced in this Policy are only those copayments charged under AHCCCS, and do not apply to other copayments such as Medicare copayments.

II. DEFINITIONS

COPAYMENTS

A monetary amount that a member may be required to pay directly to a provider at the time a covered service is rendered. AHCCCS has two types of copayments:

1. Mandatory: Providers can deny services to members who do not pay the copayment.
2. Non-Mandatory (also known as "nominal" or *optional*): Providers are prohibited from denying the service when the member is unable to pay the copayment.

COPAYMENT LEVELS

Copayment requirements will be indicated via a member specific copayment level found in all AHCCCS eligibility verification processes other than Interactive Voice Response (IVR). Every member will be assigned a copayment level which will reflect whether they are exempt from copayments, subject to non-mandatory (nominal/optional) copayments, or subject to mandatory copayments.

PROVIDER PREVENTABLE SERVICES

Services provided for a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in 42 CFR 447.26.

VISIT

All services received in one day from a single provider, or components of the same service received in one day from multiple providers, e.g. a surgery in an Ambulatory Surgical Center (ASC) where both the ASC and the surgeon provide the same service.

III. POLICY

A. MANDATORY COPAYMENTS

Individuals eligible for AHCCCS through the Transitional Medical Assistance (TMA) program are subject to mandatory copayments for the services listed below.

TMA COPAYMENTS

SERVICE	COPAYMENT
Prescriptions (per drug)	$2.30
Doctor or other provider outpatient office visits for evaluation and management	$4.00
Physical, Occupational and Speech Therapies	$3.00
Outpatient non-emergency or voluntary surgical procedures	$3.00

B. NON-MANDATORY (NOMINAL/OPTIONAL) COPAYMENTS

1. Individuals eligible for AHCCCS through the following programs are subject to Non-Mandatory Copayments:
   a. A caretaker relative eligible under A.A.C. R9-22-1427(A),
   b. Young Adult Transitional Insurance (YATI) for young adults who were in foster care,
   c. State Adoption Assistance for Special Needs Children,
   d. Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled,
   e. SSI Medical Assistance Only (SSI MAO) for individuals who are age 65 or older, blind or disabled,
   f. Freedom To Work (FTW).

2. Non-Mandatory copayments for members enrolled in the programs listed above are as follows:

SERVICE	COPAYMENT
Prescriptions (per drug)	$2.30
Physical, Occupational and Speech therapies	$2.30
Doctor or other provider outpatient office visits for evaluation and management	$3.40

C. MEMBERS AND SERVICES EXEMPTED FROM COPAYMENTS

Some populations and services are not subject to copays as outlined below:

1. Copayments are **not charged** to the following persons:
   a. Children under age 19,

b. People determined to be Seriously Mentally Ill (SMI),
c. An individual with a Children's Rehabilitative Services designation,
d. ACC members who are placed in nursing facilities or residential facilities such as an Assisted Living Home when such placement is made as an alternative to hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year. See notification requirement in #2 below.
e. People who are enrolled in the Arizona Long Term Care System (ALTCS),
f. People who are eligible for Qualified Medicare Beneficiary (QMB) A.A.C. Title 9, Chapter 29,
g. People who receive hospice care. See notification requirement in #2 below.
h. American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638, or urban Indian health programs,
i. Breast and Cervical Cancer Treatment Program (BCCTP) for Women,
j. An adult eligible under A.A.C. R9-22-1427(E).
k. An individual with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age,
l. An individual with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age, or
m. An individual who is pregnant and through the postpartum period following the pregnancy.

2. When a member meets the criteria for copay exemption as described in Section C. 1. d. and g. of this Policy, the Contractor shall notify AHCCCS Member Contact and Data Unit (MCDU) by emailing a completed copy of Attachment A to AHCCCS MCDU within five days of admission or services being provided and upon discharge from the below settings.

3. Copayments are **not charged** for the following services:
   a. Hospitalizations,
   b. Emergency services,
   c. Family Planning services and supplies,
   d. Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women,
   e. Services paid on a Fee-for-Service basis,
   f. Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms, and
   g. Provider preventable services.

D. COPAYMENT COLLECTION

Providers are responsible for billing members for the copayment amount at the time of service. This applies to members with non-mandatory copayments as well as members with mandatory copays.

1. Mandatory copayments permit providers to deny services to members who do not pay the copayment. Payments to providers will be reduced by the amount of a member's copayment obligation regardless of whether or not the provider successfully collects the mandatory copayment.

2. Non-Mandatory copayments apply to AHCCCS members who are not required to make the mandatory copayments. When a member has a non-mandatory copayment, providers are prohibited from denying the service when the member is unable to pay the copayment. The provider's reimbursement cannot be reduced by the amount of the copayment for members with non-mandatory copayments if the member is unable to pay.

E. ENCOUNTER SUBMISSIONS

Refer to the AHCCCS Encounter Manual for more information on the reporting of copayments on encounter submissions.

F. COPAYMENT LIMITS

Members subject to copays will not be required to pay additional copayments once the total amount of copayments made is more than 5% of the gross family income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December).

AHCCCS will track each member's specific copayment levels by service type to identify those members who have reached the 5% copayment limit.

With the exception of prescription drugs (where a copay is charged for each drug received), only **one** copay may be assessed for services received during a visit. If the coding for the visit falls within more than one copayment category, the member is responsible for the highest copayment amount.

G. COPAYMENT INFORMATION

For more information regarding copays, refer to the AHCCCS Copayments page on the AHCCCS website and ACOM Policy 201.